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Research Deliverable 4.0

Policy Options Overview and Conclusions

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Policy Options Overview and Conclusions

Overview

The Policy Options Briefing Book is intended to inform discussions and decisions about how the state of Washington could best expand health insurance coverage and access to health services. Its goal is to help policy makers, agency and program managers, and other interested parties choose the most fruitful strategies for further development and assessment based on up-to-date research and experience.

This report is presented to the program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the multi-disciplinary consultant team under contract to the Washington State Planning Grant staff, which coordinated the project under a grant from the federal Health Resources and Services Administration. The purpose of the grant project is to develop a comprehensive understanding of people who do not have adequate health insurance and to use this information in developing policy options to fill gaps and overcome barriers to coverage. The grant has a particular focus on public/private partnerships.

Why Are Some Options Analyzed but Not Others?

The 23 individual policy options discussed in the pages that follow were chosen for various reasons. First, the selected options are generally consistent with the project's Guiding Principles developed by the Washington State Planning Grant team to give context and guidance to the consultant team. In particular, the Guiding Principles say that potential options should:*

- Seek to expand private/public partnerships
- Reduce existing system complexities
- Be incremental and focused, preferably within a context of longer-range solutions
- Maintain consumer protections and choice but allow for regulatory or statutory simplification
- Be voluntary and incentive-based

In addition, we chose to include policy options because: they have been tried in Washington or elsewhere; they have been or are being considered seriously in policy circles at the local, state, or federal level; they have been evaluated by policy analysts or researchers; or they represent innovative models that the consultant team thinks may hold some promise. We chose a broad range of options to illustrate the spectrum of possibilities within each broad category—some that have been well tested in other places and some that are more novel, some that require a good deal of government intervention and others that do not.

* Of the principles set forth by the Washington State Planning Grant team, the five principles listed here are the ones that were most useful in choosing which policy options to analyze (for a complete list of the principles, see Appendix A or www.ofm.wa.gov/accesshealth/principles.htm).

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Many in the state and national health policy community consider expansion of public insurance programs to be a viable, often preferable, approach to extending coverage to non-elderly, low-income uninsured people. The most commonly discussed options include:

Attaining enrollment of all individuals eligible for existing public programs. Many states, including Washington, have undertaken aggressive efforts to reach out to and enroll people who are eligible for existing programs. Such efforts include increasing education and outreach to the eligible population and simplifying the enrollment processes and addressing administrative barriers to enrollment (e.g., reducing income re-certification frequency, streamlining applications, eliminating asset tests, implementing joint program applications). Increasing the success of outreach efforts could potentially cover the 88,000 children (76 percent of all uninsured children) who are now uninsured but eligible for SCHIP or Medicaid, reducing the uninsurance rate for children to less than 2 percent.

Expanding eligibility for children. Many states have expanded or are exploring expansions of Medicaid or SCHIP income eligibility for children up to as much as 200 percent FPL. Medicaid and Basic Health eligibility for children in Washington is already at 200 percent FPL, and SCHIP eligibility is at 250 percent FPL.

Extending eligibility to more adults. Some states have sought to use SCHIP funds to cover the parents of covered children; for example, California received federal approval to cover these parents with incomes up to 200 percent FPL. Another option is to expand eligibility for childless adults who are not currently eligible for Medicaid (childless adults are eligible for Medicaid only if they have specific disabilities and very low incomes). Our estimates suggest that if Basic Health were fully funded—that is, had subsidized "slots" allowing all state residents who are now eligible (uninsured with incomes up to 200 percent FPL) to enroll—the proportion of all uninsured adults with access to affordable coverage would rise from 25 percent to 75 percent.

At the direction of State Planning Grant staff, the consultant team did not include public program expansions in their background work.* This decision reflects the SPG staff's assessment of practical reality on several levels: (1) focusing consultant resources where they were most needed; (2) recognizing that Washington has already taken steps related to public programs (e.g., expanding public insurance eligibility to 200 percent FPL); and (3) the grant's interest in private/public partnerships (including but not solely focused on public programs) for their intrinsic value but also in light of state budget challenges. As this report was being written, the state Legislature struggled to bridge a gap of about $1.6 billion out of a total budget of $22.8 billion, a gap caused by rising health care spending, the recession, and the aftermath of the September 11 attacks. Medicaid caseloads are projected to grow 7 percent during the 2001-2003 biennium, and medical costs per person are increasing more rapidly than expected. This fiscal situation is believed to overshadow any discussion of expansion of public programs.

The evidence reviewed for this project strongly suggests that the most effective strategies for reducing the number of uninsured individuals and families are those that cost the most money,

* However, the use of public structures and funding are addressed as specific components under other policy option categories. Public subsidies of private insurance premiums are included as design options in Research Deliverables 4.1.1 *Financial Incentives to Individuals and Families* and 4.1.2 *Financial Incentives to Employers.* State funding (through tax credits or grants) for charity care or safety net services is considered in Research Deliverable 4.1.4 *Direct Provider Subsidies for Safety Net or Charity Care Services.*

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including public program expansions such as those noted above. Subsidies for more people and higher subsidies for each person covered—either through additional funding for public programs or subsidies for individuals/families—would likely go farthest in expanding access to health insurance (but may contradict other public policy goals, such as minimizing the substitution of public for private coverage).

In addition to public program expansions, some other potential options are not included:

- Approaches that entailed broad, comprehensive, statewide reform of the health care financing and delivery system—such as a single payer model—were deemed outside the scope of the project, because they were not consistent with the "be incremental" and "be voluntary" guiding principles. However, we discuss an individual mandate for catastrophic coverage (see Research Deliverable 4.1.5 *Market and Regulatory Reforms to Expand Health Insurance Coverage*), because this option has received some attention from stakeholders and policy makers in recent months.
- Approaches that would require either a complete redesign of public health insurance programs or a major change in Washington's tax system were also excluded. For example, to apply medical savings accounts (MSAs) or defined contribution systems[*] to Medicaid or Basic Health would require a plethora of state and federal statutory and/or regulatory changes as well as a complete shift in how the state manages these programs. A major incentive to promote MSAs is that the money in such an account is not taxed; Washington would probably need to first create an income tax in order to provide this incentive to individuals, which is unlikely given that voters have repeatedly rejected such a tax. However, the catastrophic benefits aspect of MSAs is similar to the individual mandate for catastrophic coverage option (see Research Deliverable 4.1.5 *Market and Regulatory Reforms to Expand Health Insurance Coverage*).

Why Do We Discuss Efficiency and Administrative Simplicity in a Study About Health Insurance Coverage and Access?

The health care system in Washington State, and the U.S. as a whole, is highly fragmented and complex, which has two general effects. First, it leads to inefficiencies in service delivery, data collection and transmission, and administrative functions, which wastes scarce resources. Second, the complexity frustrates users of services, purchasers of insurance, and providers, alike, to the point where consumers may decide to delay or avoid seeking needed services, purchasers may not obtain coverage that is available to them, or health care clinicians may not provide care to certain types of patients, thus creating access problems. Creating a more affordable system via strategies that avoid unnecessary costs, reduce provider administrative burden, and set the stage for effective consumer-driven buying is directly relevant to improving access.

[*] *MSAs* have two components: an individual has a high deductible catastrophic insurance policy and a special bank account—the MSA—to which he or she and/or the coverage sponsor (e.g., an employer) contribute. The individual uses the funds from the MSA to pay for services up to the deductible limit or for services otherwise not covered by the insurance policy. A *defined contribution* system provides a beneficiary with a fixed sum of money or equivalent voucher, which he or she then uses to purchase a health insurance policy. This system is in contrast to the traditional health coverage provided by employers or public programs, which offer a defined set of benefits.

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What is the Source of Data in the Briefing Book?

Unless otherwise stated, all estimates of the uninsured and insured populations—including breakdowns by age, employment status, health status, or other factors—cited in these reports are drawn from Research Deliverable 3.1 *Targeting the Uninsured in Washington State*, prepared for the Washington State Planning Grant program by the consultant team. The analyses shown in Research Deliverable 3.1 are, in turn, derived from the Washington State Population Survey and other high-quality sources described in Research Deliverable 1.0 *Data for Assessing Access to Health Insurance Coverage in Washington State.*

The Role of the Briefing Book and Next Steps

The Briefing Book provides a framework for the state's continuing efforts to design and implement strategies to expand health insurance and access. We provide analyses of a wide array of potential actions (see Research Deliverables 4.1.1 to 4.1.5 and 4.2 to 4.4) and guidance on the most promising and least promising policy options (see pages 24-26 in this report). We do not offer specific recommendations on how to improve coverage and access for two reasons. First, deciding from a range of possible actions requires value judgments—about which groups should benefit and which should bear the costs—that necessarily grow out of the public/political process. Second, the project could not analyze the *specific* impacts, costs, and strengths and weaknesses of specific policy options in detail until decisions are made about priority target groups, gaps, and barriers to be addressed and specific design options.

However, the next steps for the Washington State Planning Grant process will include activities to take these next steps: public discussions to set priorities among the most promising policy options and, then, additional analytical work to design specific interventions and project their effects and costs.

How to Use the Briefing Book

The Briefing Book is designed to make information accessible to a wide array of readers, from legislators to managers to policy analysts, with interests that range from a concise view of a full range of options to in-depth discussions of five separate policy option categories. To meet these varying needs, the binder is organized into five free-standing sections; each section can be "pulled out" separately, but together they provide a comprehensive look at potential policy options to expand coverage and improve access.

Research Deliverable 4.0 presents summary information and analyses for all policy option categories and specific strategies reviewed in this project. Most of the information is presented in matrix form to allow for easy, visual comparisons across options: a figure with summary descriptions of each option; a figure noting the potential for synergy among policy option categories; and a figure presenting the consultant team's rating of each option against a set of evaluation criteria.

Research Deliverables 4.1.1 to 4.1.5 present research findings and documentation for each of five policy option categories. Each category includes an executive summary, a definition of the problem(s) addressed by the category, and specific strategies, design options, research, and experiential evidence regarding the option, any relevant Washington State experience, findings and implications, and a bibliography.

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Research Deliverable 4.2 explores administrative simplification approaches for state government that could avoid unnecessary costs or reduce provider administrative burden, including an initial inventory of private efforts.

Research Deliverable 4.3 explores the potential to distill the range of insurance products available in the marketplace into a finite set that would maintain consumers' choices, reduce complexity and cost to the system, and increase consumers' ability to comparison shop for coverage.

Research Deliverable 4.4 reviews community-based access initiatives, presents a targeted inventory of such efforts, and analyzes barriers to and opportunities for community-state partnerships to support community initiatives.

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Summary Assessment of Policy Options

Introduction

With guidance from the SPG staff, the consultant team analyzed five categories of potential state actions that might expand coverage, enhance access, or otherwise improve the efficiency and effectiveness of some part of the health care system:

- Financial incentives to individuals and families to purchase health insurance
- Financial incentives to employers to purchase health insurance for their employees
- Health insurance purchasing pools
- Direct subsidies for safety net or charity care services
- Insurance market regulations

Each of the five policy strategies is described in some detail in Research Deliverables 4.1.1 to 4.1.5, with their main features and inter-relationships described in the following three summary tables:

Summary Table 1 summarizes information about each category and related specific strategies, including: a brief description; target population; gaps and barriers addressed; relevant Washington state context and history; and potential effects of the options in Washington.

Summary Table 2 presents a quick view of potential synergies among the categories of policy options; that is, might two types of options be mutually dependent, supportive, independent, or conflicting if implemented together. These potential synergies are discussed briefly, following the table.

Summary Table 3 presents how the consultant team rates each policy strategy against six major criteria: effectiveness in insuring high-risk individuals; effectiveness in insuring low-income individuals; effectiveness in improving access to health services for the uninsured; benefit per dollar of new state spending; cost to the state; and implementation feasibility. Definitions for these criteria can be found following Table 3. For each we used a continuum scale in which a score on the left hand of the continuum always means the strategy rates poorly against the criterion and a score on the right hand of the continuum always means a positive rating. Since the effects of a policy strategy depend largely on how it is designed and implemented and whether sufficient resources are allocated, we made the following assumption in order to standardize the rating process:

The policy strategy is optimally designed and adequately funded for its intended purpose(s).

In addition, the rating is presented as a point on the scale within a “confidence interval” to reflect the sometimes substantial uncertainty or lack of consensus in the research or policy literature.

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Summary Table 1. Description of Major Policy Options

(Data in this table are drawn from Research Deliverable 3.0, *Profiles of the Uninsured*, or from the individual policy option reports, Research Deliverables 4.1.1 to 4.1.5. Please refer to these reports for data source and year. Population figures refer to people aged 0-64 unless otherwise indicated.)

Option	Option Description	Target Population Addressed by Option	Barrier (process, structure, or systemic) Addressed by Option	Washington State Context and History	Potential Effects in Washington
I. Financial Incentives to Individuals and Families					
1. Subsidies to low-income individuals	Provide tax credits (through federal programs), vouchers or other subsidies to assist low-income individuals/families without employer-sponsored coverage to secure coverage.	Most (~65%) of the uninsured have low incomes (<200% FPL), about 308,000 state residents. Of this group, 87% (268,000) do not have access to employer-sponsored coverage.	Premiums in the commercial individual market may be unaffordable to low-income individuals due to underwriting and high administrative costs. Many employers do not offer health insurance.	BH/BH Plus expanded statewide (1993) to subsidize coverage for low-income people. Established SCHIP (2000) to expand eligibility for publicly subsidized coverage with premium and co-payment cost sharing for children in families with incomes between 200%-250% FPL.	Estimates of the effects of different levels of subsidies vary widely and are subject to a great deal of uncertainty. Potential reductions to the current 9.2% uninsured rate for a subsidy for everyone (not just low-income or other subgroups): 25% subsidy – 8.4% 50% subsidy – 7.6% 75% subsidy – 6.8% Estimates of potential substitution of public (subsidized) coverage for private also vary widely and are subject to a great deal of uncertainty. As many as 50% of participants in a subsidy program may have purchased coverage without the subsidy. Substitution increases with income.
2. Subsidies to high-risk individuals	Subsidize premiums for individuals with high expected or actual medical costs through Washington State Health Insurance Pool (WSHIP or "high-risk pool")	People with high expected or actual medical costs who are unable to obtain private coverage through the private market. People in fair/poor health have twice the rate of uninsurance (15%) as those in excellent or very good health (6.8%).	Premiums in WSHIP (set at 125% or 150% of commercial premiums) may be unaffordable to low-income, high-risk individuals. State law allows health plans to screen out 8% highest risk.	WSHIP created in 1988 to serve medically uninsurable. Funded via assessments on insurers, stop-loss and re-insurance carriers, and limited enrollee premiums. As of 2000, about 2,200 (monthly average) enrolled in WSHIP, less than 1% of individual market (source: WSHIP).	See estimates for individual subsidies, above; no separate estimates for high-risk individuals.

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Option	Option Description	Target Population Addressed by Option	Barrier (process, structure, or systemic) Addressed by Option	Washington State Context and History	Potential Effects in Washington
3. COBRA subsidies or reforms (for transitional coverage)	Subsidize COBRA premiums for individuals and their families during employment transitions.	About 12.5% of the uninsured (60,000 people) recently lost a job or were looking for work.	About 80% of eligible workers do not buy COBRA coverage, primarily due to cost. Individual market options may not be affordable. BH enrollment caps may limit access to more affordable, subsidized coverage.	Federal COBRA laws require employers with more than 20 employees to offer health coverage to all employees who quit or lose their jobs; employees must pay 102% of the group premium. Washington does not have regulations that require smaller employers to offer such coverage (which 38 other states have).	Due to eligibility restrictions, about 11% of the uninsured (53,000) and 13% of the low-income uninsured (40,000) would benefit from COBRA subsidies.
4. Premium assistance programs	Provide contributions to employees' share of employer-based insurance premium for those with low-incomes.	About 13% of low-income (<200% FPL) uninsured people (40,000 individuals) have access to employer-based coverage.	Premium requirements for some employer-sponsored health insurance may be unaffordable to some individuals and families; about 20% of people with access to employer-sponsored coverage are unable to afford the costs.	Basic Health offers a limited program for employers to pay the employee's BH premiums if the firms meet participation and enrollment criteria. Medicaid's Health Insurance Premium Payment (HIPP) program subsidizes limited enrollment in employer-sponsored coverage for Medicaid-eligible people and their families. HIPP enrollment is limited by complex administrative requirements and limited eligibility for uninsured adults.	No estimates of effects, but since only about 17.5% of the uninsured are in firms that offer coverage, the impact on the overall uninsured rate is likely to be modest.
II. Financial Incentives to Employers					
1. Voluntary subsidies to employers	Provide subsidies or tax credits to targeted (or all) employers to reduce the price of coverage and expand number of employers offering coverage. Characteristics of firms targeted for subsidies could include: small; low-wage; predominantly seasonal or part-time; or type of industry. Most existing subsidies in other states target small businesses.	Of the uninsured, 76.4% (370,000 people) are in households with at least one worker. Of this group, 30.2% (112,000) work for employers that do not offer coverage, and 45.5% (168,000) are self-employed. 53.9% of workers in firms with <10 employees are offered coverage vs. 92.0% in firms with >50 employees. 63.0% of workers in seasonable businesses are offered coverage vs. 81.2% in other businesses. 60.7% of workers in predominantly low-wage	Employers may chose whether to offer coverage, a decision based on many factors, including the nature of the business, the competitiveness of its market, the financial well-being of the firm, the values or philosophy of the employer, whether the workforce is unionized, as well as the cost of health insurance, *per se*.	The 1993 Health Services Act proposed to provide subsidies to employers to help them meet the Act's mandate to provide coverage. The Act was repealed before these provisions could be implemented.	A subsidy to small businesses (<50 workers) of 50% of premium could increase the proportion of firms offering insurance from the current 39.4% to 42.1%, and the proportion of workers offered coverage from current 83.4% to 84.1%.

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Option	Option Description	Target Population Addressed by Option	Barrier (process, structure, or systemic) Addressed by Option	Washington State Context and History	Potential Effects in Washington
		businesses are offered coverage vs. 85.1% in other businesses. 38.6% of workers in firms with predominantly part-time employees are offered coverage vs. 82.7% in other firms.			
2. Play-or-pay mandate on employers	Require firms to offer coverage or pay a tax to support public coverage for their employees.	23.1% of the uninsured (about 112,000 people) are workers/dependents without access to employer-sponsored coverage.	Employers may chose whether to offer coverage, a decision based on many factors, including the nature of the business, the competitiveness of its market, the financial well-being of the firm, the values or philosophy of the employer, and whether the workforce is unionized, as well as the cost of health insurance, *per se*.	The 1993 Health Services Act included an employer mandate, but was repealed in 1995 before being implemented. A congressional change to the federal ERISA law would have been required to enforce the mandate.	A mandate to *offer* coverage would not result in universal coverage unless coupled with an individual mandate, due to worker preferences and affordability. Small businesses would be more likely to "pay" due to higher premiums for small group products. Mandate could result in a loss of about 0.1% of jobs.
III. Purchasing Pools					
1. Employer-based pools	Pooled and centrally administered purchasing of health care coverage on behalf of, or by, businesses to: (1) obtain lower premiums through volume purchasing and spreading of risk, (2) reduce costs by centralizing administrative functions and improving negotiating power with providers, (3) promote price/quality competition among participating plans, and (4) increase choices available to individuals, families, and participating groups.	Pools often are targeted to assist employers most likely to have uninsured workers. For example: 53.9% of workers in firms with <10 employees are offered coverage vs. 92.0% in firms with >50 employees. 63.0% of workers in seasonable businesses are offered coverage vs. 81.2% in other businesses. 60.7% of workers in predominantly low-wage businesses are offered coverage vs. 85.1% in other businesses. 38.6% of workers in firms with predominantly part-time employees are offered coverage vs. 82.7% in other firms.	Private health insurance premiums for small businesses are higher than large groups, in part because they represent small risk pools and because administrative costs are higher.	Several pooling arrangements exist in Washington, primarily as employer pools, such as the Washington Counties Insurance Fund, Employers Health Purchasing Cooperative, Association of Washington Businesses. The 1993 Health Services Act would have created four health insurance purchasing cooperatives (one for each region of the state) to pool purchasing for individuals and groups. The Act was repealed before this provision could be implemented.	Unknown effects on affordability and uninsured rates, but evidence to date suggests small impacts.

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2. Individual or individual/small group market-based pools	Same as above, but for individuals and/or small groups.	Of the uninsured, 82.5%, totaling about 399,000 people, are unemployed, self-employed, or work for an employer that does not offer coverage. Workers in small firms are less likely to be offered coverage. For example, 53.9% of workers in firms with <10 employees are offered coverage vs. 92.0% in firms with >50 workers. If offered coverage, it often costs much more than larger firms. 20% of people offered employer-sponsored coverage unable to afford it.	In the commercial market, health insurance premiums are much higher for individuals and small groups, in part due to the small size of the risk pools they are in and because administrative costs are higher. Also, underwriting can make coverage unavailable.	BH/BH Plus–state subsidized and unsubsidized health insurance purchasing pools for low-income individuals and certain businesses; WSHIP–high-risk insurance pool for individuals who cannot afford private individual coverage.	Unknown effects on affordability and uninsured rates, but evidence to date suggests small impacts.
3. Other community-rated pools	Same as above, but pooling based on characteristics other than employment, such as residence in particular community.	Of the uninsured, 82.5%, totaling about 399,000 people, are unemployed, self-employed, or work for an employer that does not offer coverage. Communities with higher rates of uninsurance: for example, 15.7% of East Balance residents are uninsured (vs. 8.4% in King County), 27.9% of Native Americans /Alaskan Natives and 22.6% of Hispanics are uninsured).	Existing insurance pools tend to fragment risk into low- and high-risk groups, resulting in some people being unable to obtain or afford coverage. In addition, employer-based pools can lead to discontinuity of coverage when employment status changes.	Several Washington communities and groups developing or considering alternative mechanisms to ensure access to insurance coverage and health care services for their members. Examples include the Spokane Health Insurance Partnership, the Jamestown S'Klallam Managed Care Program, and the CHOICE Regional Health Network. (See Research Deliverable 4.4 *Community Access Initiatives*.)	Unknown effects on affordability and uninsured rates.

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Option	Option Description	Target Population Addressed by Option	Barrier (process, structure, or systemic) Addressed by Option	Washington State Context and History	Potential Effects in Washington
4. Mobile worker pools	Same as above, but for workers who frequently change employers.	Uninsured workers in certain industries with high mobility (e.g., construction, wood products, retail), seasonality (agriculture), or high use of part-time or temporary/contract workers (e.g., health care, high technology). Coverage offered to 63% of employees in seasonal businesses and 65% of employees in predominantly part-time businesses vs. 81% of employees in non-seasonal businesses.	Worker mobility makes it difficult for employers to provide coverage, leaving these individuals to seek coverage in the individual market; such coverage may not be affordable.	Pools exist in selected industries (e.g., wood products, construction) through Multiple Employer Welfare Arrangements, union, or Taft-Hartley trusts.	Unknown effects on affordability and uninsured rates.
5. Consolidated, state-funded pools	Consolidate selected state-administered pools (e.g., BH, public employees, and Medicaid) to achieve economies of scale and streamline administrative costs.	Approximately 1.3 million state residents receive coverage through BH, Medicaid, or as a public employee.	The various public insurance programs differ in significant ways, including: program goals and purposes, type of beneficiaries, eligibility requirements, benefits, cost-sharing, administrative structures, agency cultures, and political constituencies.	1990 Health Care Authority Study of State Purchased Health Care concluded phased-in consolidation could promote better cost management and coordination of health purchasing policies and services across state agencies.	Unknown effects on affordability and costs/ expenditures.
IV. Direct Provider Subsidies					
1 Expand HCA Community Health Services Grant Program	Expand HCA's Community Health Services (CHS) grant program with funds distributed according to number of uninsured served by clinics.	Most uninsured people (64.5%) have low incomes (<200% FPL), about 308,000 people. For this group, about 25% of adults and 10% of children lack access to affordable coverage. High unemployment rates (7.5% in Jan. 2002) correlate with higher uninsurance rates–18.5% of uninsured in families without employment vs. 11.5% with one employed family member and 3.8% with 2 employed family members. About 12.5% of the uninsured (60,000 people) recently lost a job	Changes in health care delivery and financing have reduced the ability of some providers to serve “charity” patients, given current payment rates (both public and private) and operating expenses. If paying out of pocket, health care services are expensive and getting more so.	Health Care Authority administers CHS grant program that provided $6m in funding in 2000. CHS grants provided 26.7% of total clinic funding to partially support 341,000 medical clients and 114,000 dental clients served by 29 community-based organizations. In 2000, 29% of Washington Association of Community and Migrant Health Centers (WACMHC) clients were uninsured and paid sliding scale fees.	Unknown effects on access.

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		or were looking for work.			
2. Create a discount card	Create program for low-income uninsured to purchase a discount card that enables them to obtain care from participating providers. May partner with local communities or local provider networks to pilot discount card approaches. May use Community Health Services grantees or investigate feasibility of using UMP preferred providers as provider network.	Most uninsured people are low-income (<200% FPL), about 308,000 people . Rural areas, particularly Eastern Washington, have higher rates of uninsurance and more limited access to CMHC/RHC services than urban areas. Certain populations are more likely to be uninsured - particularly Native Americans/Alaskan Natives (27.9% uninsured) and Hispanics (22.6% uninsured).	If paying out of pocket, health care services are expensive and getting more so.	No specific history with discount cards, although one Central Washington community is exploring the idea. Pilot projects in early development in Arizona and Hawaii.	Unknown effects on access.
3. Increase payment to providers through health plan premiums	Increase premiums to state-contracted health plans (BH, PEBB, Healthy Options) that then increase payment to providers in order to expand their capacity to provide charity care to uninsured.	About 65% of uninsured state residents have low incomes (<200% FPL), about 308,000 people, and likely cannot afford to pay for health care.	Changes in health care delivery and financing have reduced the ability of some providers to serve "charity" patients, given current payment rates (both public and private) and operating expenses.	No directly relevant experience. When Washington's Medicaid program increased payment to physicians (directly, not through health plans) for obstetric care as part of the First Steps Program in the late 1980s, access improved.	Unknown effects on access.

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Option	Option Description	Target Population Addressed by Option	Barrier (process, structure, or systemic) Addressed by Option	Washington State Context and History	Potential Effects in Washington
4. Uncompensated care pools	Set up uncompensated care pool to enhance revenues for hospitals or other providers who provide disproportionate share of services for uninsured. Two options: (1) Internal financing–hospital charity care resources pooled and funds distributed from pool to hospitals based on proportion of charity care provided, and (2) External financing–Funded from outside revenue source, such as dedicated tax, and distributed based on charity care provided (number of patients or percentage of revenues).	About 65% of uninsured state residents, about 308,000 people, have low incomes (<200% FPL) and likely cannot afford to pay for health care. Demand for hospital-based charity care increased by 10.4% (from $102 million to $112 million) between 1997 and 1999.	Some providers carry a "disproportionate" share of charity care for low-income, uninsured patients. For example, 19 of the state's 90 hospitals provided 76% of hospital-based charity care in 1999. Charity care is not "free," but rather must be paid for from other revenues. Thus, providing charity care can become a financial hardship for the provider and place it at a competitive disadvantage in relationship to its competitors.	In 1983-1984, policy makers considered developing an internally financed hospital charity care pool. The effort did not generate sufficient political momentum and was not implemented.	Unknown effects on access.
5. Create a tax credit for not-for-profit hospitals	Extend B&O tax credit to not-for-profit hospitals. Tax credit tied to number of uninsured served or percentage of revenues used for charity care.	About 65% of uninsured state residents, about 308,000 people, have low incomes (<200% FPL) and likely cannot afford to pay for health care. Demand for hospital-based charity care increased by 10.4% (from $102 million to $112 million) between 1997 and 1999.	Charity care is not "free," but rather must be paid for from other revenues. Thus, providing charity care can become a financial hardship for a hospital and place it at a competitive disadvantage in relationship to its competitors. Changes in health care delivery and financing have reduced the ability of some providers to serve "charity" patients, given current payment rates (both public and private) and operating expenses.	In 1993, Legislature removed a B&O tax exclusion for not-for-profit and public hospitals and required B&O tax on non-governmental revenue to fund BH expansion.	Unknown effects on access.
6. Create a tax credit for physicians, physician assistants, and nurse practitioners	Offer B&O tax credit to physicians, physician assistants and nurse practitioners (or their business entities) who provide care for the uninsured.	About 65% of uninsured state residents, about 308,000 people, have low incomes (<200% FPL) and likely cannot afford to pay for health care.	Charity care is not "free," but rather must be paid for from other revenues. Thus, providing charity care can become a financial hardship for	No specific history with B&O tax credits for providers.	Unknown effects on access.

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Option	Option Description	Target Population Addressed by Option	Barrier (process, structure, or systemic) Addressed by Option	Washington State Context and History	Potential Effects in Washington
			health care providers and place them at a competitive disadvantage in relationship to competitors. Changes in health care delivery and financing have reduced the ability of some providers to serve "charity" patients, given current payment rates (both public and private) and operating expenses.		
7. Expand federal Health Professional Shortage Areas (HPSAs)	Governor-designation of all eligible areas as HPSAs. Enables providers in undesignated rural areas to apply for rural health center (RHC) designation to enhance their Medicare /Medicaid revenues.	Low-income (<200% FPL) uninsured in mostly rural areas, such as East Balance (15.7% uninsured), West Balance (11.2% uninsured), and North Sound (12.4% uninsured).	Changes in health care delivery and financing have reduced the ability of some providers to serve "charity" patients, given current payment rates (both public and private) and operating expenses. Rural areas have fewer safety net providers, leaving the burden to private health care practices.	State Department of Health (DOH) estimated that federal HPSA designation allowed local clinics, providers, and health jurisdictions to qualify for $35 to $50 million in federal funds. DOH aggressively pursues HPSA designations– almost 90% of the state lies in a HPSA.	Unknown effects on access, although physicians interviewed in *The State Primary Care Study* (2001) reported that RHC status was an important factor in stabilizing their practices.
8. Expedite the application process for rural health center (RHC) designation	State provides technical assistance to physician practice staff in applying for RHC designation.	Low-income (<200% FPL) uninsured in mostly rural areas, such as East Balance (15.7% uninsured), West Balance (11.2% uninsured), and North Sound (12.4% uninsured).	Changes in health care delivery and financing have reduced the ability of some providers to serve "charity" patients, given current payment rates (both public and private) and operating expenses. Rural areas have fewer safety net providers, leaving the burden to private health care practices.	State Department of Health (DOH) estimated that federal HPSA designation allowed local clinics, providers, and health jurisdictions to qualify for $35 to $50 million in federal funds. 75 health care practices are certified RHCs, 40 others have expressed interest (as of 4/02). Federal government RHC surveys are currently a low priority.	Unknown effects on access, although physicians interviewed in *The State Primary Care Study* (2001) reported that RHC status was an important factor in stabilizing their practices.
V. Market and Regulatory Reforms					

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Option	Option Description	Target Population Addressed by Option	Barrier (process, structure, or systemic) Addressed by Option	Washington State Context and History	Potential Effects in Washington
1. Relief from benefit mandates	Reduce or eliminate state requirements that insurers cover specific services or types of providers. Could be applied to all insurance products or only to certain markets, such as small group or individual.	Potentially targets all state residents except those covered by self-funded employers (already exempt from state mandates) and the uninsured. Of all workers, 57.0% are in firms with 50+ workers; 7.7% in firms with 25-49; 13.3% in firms with 10-24; and 22.0% in firms with <10. 6.4% of state residents have individual coverage.	Mandates reduce some flexibility and choice in the voluntary, private health insurance market.	Washington State has 22 mandated benefit laws–10 affect group coverage, 12 affect both individual and group products. Mandates include coverage for specific services, access to certain licensed providers, administrative mandates governing eligibility or rules for continued coverage. In 1990, the Legislature authorized "value" small group products exempt from benefit mandates. Value products experienced very low demand.	Effect on affordability or uninsured rates likely low.
2. Individual and small-group market regulations	Restructure distribution of risk in individual and small-group markets.	6.4% of state residents (335,000 people) have individual coverage. In addition, 9.2% (484,000) are uninsured and, thus, potential applicants for individual coverage. About 75% of the uninsured (363,000) are in households with at least one worker; of which many work for small employers. Of all workers, 57.0% are in firms with 50+ workers; 7.7% in firms with 25-49; 13.3% in firms with 10-24; and 22.0% in firms with <10.	Market forces often exclude or lead to higher, unaffordable premiums for some individuals and groups. In competitive individual and small-group markets, health plans limit their risk exposure through risk-rated premiums, medical underwriting, waiting periods, and pre-existing condition exclusions.	With exception of community rating bands, Washington regulations are similar to other states but not linked across individual and small-group markets. After insurance market reforms of the early 1990s, the individual market was marked by instability and declining access in areas of the state. The Health Insurance Reform Act (HIRA) was passed in 2000 to attract insurers back into individual market by allowing them to screen out 8% of highest-risk applicants.	Effect on affordability or uninsured rates likely low. May improve access to health insurance for some high-risk individuals.
3. High-risk pool expansion	Modify the state high-risk pool to remove more people with high-risk medical conditions from the private individual or small-group markets.	People in fair/poor health have twice the rate of uninsurance (15%) as those in excellent or very good health (6.8%). About 60% of uninsured adults in fair/poor health do not have access to affordable coverage.	In competitive individual and small-group markets, health plans limit their risk exposure through risk-rated premiums, medical underwriting, waiting periods, and pre-existing condition exclusions. HIRA 2000 allows insurers to screen out the 8% highest-risk applicants, who are then	Washington State Health Insurance Pool was created in 1988 to serve medically uninsurable individuals. WSHIP is funded by premiums (set at 125%-150% of commercial rates) and assessments on insurers, stop-loss, and re-insurance carriers. As of 2000, average monthly enrollment was about 2,200, ~0.3% of individual market (source: WSHIP).	Effect on uninsured rates and affordability likely low. Since HIRA 2000, 240 of 1,448 (16.6%) individuals rejected for individual coverage have enrolled in WSHIP.

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Option	Option Description	Target Population Addressed by Option	Barrier (process, structure, or systemic) Addressed by Option	Washington State Context and History	Potential Effects in Washington
			eligible for WSHIP.		
4. Universal catastrophic coverage	Provide mandated access to high-deductible, low-cost catastrophic coverage for all Washington residents under age 65.	Potentially targets all state residents (all state residents under age 65 total 5,241,000), especially the 9.2% (484,000) who are uninsured, of whom 308,000 have income <200% FPL and 176,000 have incomes >200% FPL.	Market forces often exclude or lead to higher, unaffordable premiums for some individuals and groups. In a voluntary system, individuals may chose not to buy coverage even if it is available and affordable.	No directly relevant experience in Washington (or any other state). Some catastrophic policies are sold in Washington, but the total market is unknown. Some policy-makers proposing examination of universal catastrophic coverage as potential option to address lack of access to affordable insurance.	Likely to significantly improve affordability and reduce the uninsured rate.

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Summary Table 2. Potential Synergy Between Policy Option Categories

	Individual/ Family Incentives	Employer Incentives	Purchasing Pools	Direct Provider Subsidies	Market and Regulatory Reforms
Individual/ Family Incentives					
Employer Incentives	S				
Purchasing Pools	D/S	D/S			
Direct Provider Subsidies	S/I	S/I	I		
Market and Regulatory Reforms	S/I	S/I	S	I	

Dependent Supportive Independent Conflicting

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Potential Synergy Between Policy Option Categories

As Summary Table 1, above, shows, the various policy options we looked at address certain gaps in and barriers to coverage. In some cases, two or more policy options may address the same or similar problems or populations, or come at the same problem in different ways. As they consider the best approaches to expanding coverage and access, state policy makers should consider these potential synergies—the "whole" effect of a combination of strategies may be greater than the mere sum of the effects of the individual strategies.

Summary Table 2, above, summarizes these potential interrelationships. This table should be read like a mileage chart; the same categories of policy options are listed across the top and on the left column. The relationship (Dependent, Supportive, Independent, or Conflicting) between any two options can be found in the cell where they intersect.

We briefly discuss below how the various policy option categories may interact. Our assessment of potential synergies among these general categories of policy options is necessarily general; how two specific strategies would likely interact can only be known once they are designed in detail. Only combinations that may have significant potential for being mutually supportive or for which one option may be dependent on another are discussed; the effects of at least two combinations (see table) are probably independent.

Dependence

Purchasing Pools, Individual/Family Incentives, and Employer Incentives—The analysis of purchasing pool strategies (Research Deliverable 4.1.3) suggests that, to be successful, pools must require participation of certain groups or individuals. In addition, pools must become relatively large to realize scale economies and attract health plan participation. Therefore, we conclude that the success of efforts to expand or develop purchasing pools may be dependent on incentives to employers or individuals/families. At the very least, such incentives would support pooled purchasing strategies. Sliding-scale premiums for the high-risk pool are likely to be less relevant for purchasing pool strategies, since the latter are not targeted toward high-risk individuals.

Mutual Support

Individual/Family Incentives and Employer Incentives—To the extent that individuals/ families targeted by incentives also work for employers targeted by incentives, individuals/family incentives could increase the "take-up rate" (purchase) of employer-sponsored insurance offerings. However, implementing both types of incentives has some potential for being confusing to employees and employers.

Direct Provider Subsidies and Individual/Family/Employer Incentives—To the extent that individual or employer incentives increase the proportion of state residents who have insurance, demand for charity care will drop, thus reducing pressure on providers' financial margins and allowing existing subsidies to be spread further.

Individual/Family/Employer Incentives and Market and Regulatory Reforms—Insurance market reforms may stabilize markets, but financial incentives may still be required to induce more people to buy insurance. Even insurance rating reforms may reduce access to insurance for some

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(while increasing access for others), so financial incentives may be needed to offset this adverse effect.

Market and Regulatory Reforms, Employer Incentives, and Purchasing Pools—Insurance regulation strategies are designed, in part, to stabilize especially the individual and small-group markets (which are the primary targets for purchasing pools). To the extent that employer incentives and purchasing pool strategies are successful in expanding the number of groups and individuals who are covered, they also will have the effect of expanding the size, and therefore stability, of risk pools in the insurance market. Relief from state benefit mandates might support purchasing pool strategies to the extent the mandates are viewed as restricting a pool's benefit design options or increasing the price of its product offerings.

Evaluation of Policy Options

Summary Table 3, on the following page, is a visual display of how each policy option discussed in Research Deliverables 4.1.1 to 4.1.5 rates in relation to six evaluation criteria: effectiveness in insuring high-risk individuals; effectiveness in insuring low-income individuals; effectiveness in improving access to health services for the uninsured; benefit per dollar of new state spending; cost to the state; and implementation feasibility.

The consultant team selected these evaluation criteria (their definitions can be found following Table 3) for two general reasons: First, the criteria reflect major goals and principles of the State Planning Grant, including expanding access to health insurance and health services, maximizing existing financial resources, and "do-ability." Second, the criteria reflect some of the major characteristics found in the research that distinguish one type of strategy from another.

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Summary Table 3. Rating of Policy Options Against Evaluation Criteria

= low uncertainty = medium uncertainty = high uncertainty

Criteria / Policy Options	Effectiveness: In Expanding Coverage to: Uninsured High-Risk People (none ◄► all)	Effectiveness: In Expanding Coverage to: Uninsured Low-Income People (none ◄► all)	Effectiveness: In Improving Access to Health Services for the Uninsured (none ◄► a lot)	Benefit Per Dollar of New State Spending (low ◄► high)	Cost to the State (high ◄► low)	Implementation Feasibility (difficult ◄► easy)
Individual/Family Incentives						
1. Subsidies to low-income individuals						
2. Subsidies to high-risk individuals						
3. COBRA subsidies or reforms						
4. Premium assistance programs						
Employer Incentives						
1. Voluntary subsidies						
2. Play-or-pay mandate						
Purchasing Pools						
1. Employer-based pools						
2. Individual or individual/small group market-based pools						
3. Other community-rated pools						
4. Mobile worker pools						
5. Consolidated, state-funded pools						
Direct Safety Net Subsidies						
1. Expand HCA CHS Grant Program						
2. Create a discount card						
3. Increase payments to providers through health plan premiums						
4. Uncompensated care pools						
5. Tax credit for not-for-profit hospitals						
6. Tax credit for physicians, physician assistants, and nurse practitioners						
7. Expand federal HPSAs						
8. Expedite the appication process for RHC designation						
Regulatory and Market Reform						
1. Relief from benefit mandates						
2. Individual and small-group market regulations						
3. High-risk pool expansion						
4. Universal catastrophic coverage						

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Criteria Used to Evaluate Policy Options

If the policy strategy is optimally designed and adequately funded for its intended purpose(s), what would its effect be in relation to the following criteria?

1. Effectiveness in Insuring High-Risk People

To what extent would the policy strategy be successful in expanding insurance coverage of high-risk individuals (i.e., those likely to have high medical expenses)?

Scale: *None* = no additional high-risk people would be covered

All = all high-risk people would be covered [number unknown]

2. Effectiveness in Insuring Low-Income People

To what extent would the policy strategy be successful in expanding insurance coverage of low-income individuals?

Scale: *None* = no additional low-income uninsured people would be covered

All = all low-income, uninsured people (up to 200 percent FPL) would be covered [308,000]

3. Effectiveness in Improving Access to Health Services for the Uninsured

To what extent would the policy strategy be successful in improving access to health services for uninsured individuals?

Scale: *None* = no improvement, health services use rates for the uninsured remain unchanged

A lot = use rates for uninsured individuals would increase to approximate that of insured individuals

4. Benefit per Dollar of New State Spending

For each additional dollar spent by the state, how many more uninsured or uninsured high-risk people would become insured, or how many more people would have access to needed health services, due to this strategy?

Scale: *Low* = few newly insured or little improvement in access for each state dollar spent

High = many newly insured or substantially improved access for each state dollar spent

5. Cost to the State

To what extent would the policy strategy require additional state funds?

Scale: *High* = high cost to the state

Low = low cost to the state

6. Implementation Feasibility

To what extent would the success of the policy strategy depend on new state administrative capacity and systems, new state laws or regulation, or new federal laws, regulations, or approvals? And, if new laws or regulations are needed, how difficult would they be to enact?

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Scale: *Difficult* = implementation would require many changes or new structures, regulations, or laws, and it would be difficult to bring them about

Easy = implementation could largely be accomplished within existing administrative structures, regulations, and laws

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Conclusions

The analyses of policy options contained in this briefing book were conducted with the aim of informing policy decisions over the next five or six years. Based on the available experience and research evidence, the consultant team has concluded that certain policy options have greater potential to expand health insurance coverage and access to health services. Other policy options do not have such potential and, we think, do not warrant further attention by the state of Washington.

We identify below options that are most promising and those that are least promising, based on the evidence and analyses found in Research Deliverables 4.1.1 to 4.1.5; the "scoring" in Summary Table 3 summarizes these analyses in visual form. The most promising options are generally those that rated the highest across the six evaluation criteria in the table. Although our conclusions are based on the evidence as much as possible, the incompleteness—and sometimes paucity—of information concerning many policy options means that our conclusions necessarily involve some judgment and extrapolation. Thus, our conclusions represent the consultant team's collective expertise and views.

We did not attempt to derive total or composite scores for each option from Summary Table 3, because of the subjective nature of these scores and the often wide "confidence" intervals noted on the table. In addition, we did not apply different weights to the criteria, as doing so would require value judgments that some public goals (e.g., maximize coverage, minimize state costs,) are more important than others. Rather, we used—and the reader should use—the scoring in Table 3 as a way to assess how different strategies compare against each criterion and to more easily identify each option's strengths and weaknesses.

We re-emphasize three points concerning our conclusions.

- At the direction of the State Planning Grant staff, the consultant team did not include public program expansions in their background work. This decision reflects the SPG staff's assessment of the practical realities of past initiatives in Washington and current state budget restraints. The available evidence suggests that expanding public programs is among the most effective strategies to reduce the ranks of the uninsured.
- We offer guidance about which approaches to expanding coverage or access are likely to be most fruitful and which least fruitful, but not specific recommendations for action. Decisions about which strategies the state should pursue must reflect a range of value and political judgments, which are beyond the scope of this project.
- Further decisions about specific design options are needed in order to estimate more precisely the costs and benefits of selected strategies, an analysis that should inform subsequent decisions about which approach(es) to pursue and in which to invest.

As this report was being written, the 2002 Washington State Legislature grappled with difficult choices about how to address a $1.6 billion gap between available revenues and expected costs—a gap caused by rising health care spending, the recession, and the aftermath of the September 11 attacks. This context suggests effective strategies that require fewer new state funds will be more attractive to policy makers than (possibly more) effective strategies that require more state funds. The reader can identify relatively "low-cost" strategies in Summary Table 3 by looking at ratings under the "Cost to the State" criterion, and we note them with an asterisk (*) below.

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Policy options that are not shown below are "in the middle" and, thus, may be more or less attractive, depending on decisions about priority target populations, specific design features, and additional analyses.

Most Promising Policy Options

The following policy options tend to score the highest across the evaluation criteria and show the most promise in the research for expanding access to health insurance and health services. In the view of the consultant team, they may warrant more targeted research to determine if and exactly how the state may want to pursue them.

Subsidies to high-risk individuals*

Major strengths:	Could provide access to affordable coverage for significantly more relatively sick, low-income, uninsured individuals; relatively easy to implement within existing structure.
Major weaknesses:	May require very large subsidies within a sliding scale to induce high-risk people to purchase coverage.

Expanded Health Care Authority Community Health Services grant program*

Major strengths:	Uses an existing mechanism to expand the capacity of safety net providers to serve more low-income, uninsured residents.
Major weaknesses:	Would require additional state funds; may not improve access for many more uninsured people (unless additional grantees in new areas of the state).

Expedited Rural Health Clinic application process*

Major strengths:	Would assist medical practices in obtaining higher payments and improved margins; could signal that the state seeks to be a partner with providers in serving uninsured state residents; relatively low cost.
Major weaknesses:	Not a priority for federal government; would add to state Medicaid expenditures; would affect relatively few uninsured people.

Subsidies to low-income individuals

Major strengths:	Could reach a significant number of uninsured people; could be relatively easy to implement if using existing structures (e.g., Basic Health).
Major weaknesses:	Would require large subsidies and state funding.

Universal catastrophic coverage

Major strengths:	Could provide at least a minimum of coverage for all state residents. This option would likely relieve the private sector of a significant amount of health care costs.
Major weaknesses:	Would involve very complex statutory, regulatory, administrative, and political implementation; could be relatively high cost to the state

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(depending on design features). This option would likely shift health care costs to taxpayers.

Discount cards for health care services*

Major strengths:	Could provide immediate access to services for some uninsured individuals and families and reduce charity care burden on providers; relatively low cost to the state; could be implemented within existing structures.
Major weaknesses:	Would not likely affect very many low-income or high-risk uninsured people; willingness of providers to participate unknown.

Expanded federal Health Professional Shortage Area designation*

Major strengths:	Would reduce complexity for communities and providers who seek RHC and other safety net designations; could signal that the state seeks to be a partner with providers in serving uninsured state residents; relatively low cost.
Major weaknesses:	Would add very few new areas as HPSAs; would affect relatively few uninsured people.

Least Promising Policy Options

The following policy options tend to score the lowest across the evaluation criteria and show the least promise in the research for expanding access to health insurance and health services. In the view of the consultant team, they do not warrant additional research.

Tax credits for physicians, physician assistants, and nurse practitioners

Major strengths:	Could improve providers' margins and willingness to provide charity care; could signal that the state seeks to be a partner with providers in serving uninsured state residents.
Major weaknesses:	Could affect few uninsured people; would cut state revenues; would require new data collection system.

Increase payments to providers through health plan premiums

Major strengths:	Would use existing contractual mechanism to distribute funds.
Major weaknesses:	Could affect few uninsured people for relatively high cost to the state; would require new data and administrative systems for health plans and the state.

Individual/small group purchasing pools*

Major strengths:	Could be relatively low cost to the state; could simplify health insurance market for some individuals and groups.
Major weaknesses:	Could affect few uninsured people (unless combined with very large subsidies); could be complex to implement.

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Pay-or-play mandate on employers

Major strengths:	Could improve coverage for significant number of uninsured people.
Major weaknesses:	Would involve very complex statutory, regulatory, administrative, and political implementation; could be relatively low benefits per dollar spent and high cost to the state.

Mobile worker purchasing pools

Major strengths:	Could be relatively low cost to the state; could simplify health insurance market for some individuals.
Major weaknesses:	Could affect few uninsured people (unless combined with very large subsidies); could be complex to implement.

Consolidated, state-funded pools

Major strengths:	Could reach some uninsured people (depending on design and implementation features); could simplify health insurance market for some individuals and groups; could reduce the complexity of state administrative structures.
Major weaknesses:	Would likely derive low benefits for dollar spent; could be complex to implement.

Relief from benefit mandates*

Major strengths:	Could allow for some uninsured people to obtain coverage (depending on how insurance product pricing is affected); would entail relatively little state funding (except some loss of premium tax revenues if prices drop).
Major weaknesses:	Would not likely reduce uninsurance rates significantly; demand for "value" plans has been very low in the past; could involve difficult political issues to enact.

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Appendix A

Washington State Planning Grant on Access to Health Insurance

Guiding Principles

These guiding principles provide context for work conducted under the auspices of the State Planning Grant on Access to Health Insurance. The bullets are not in any priority order.

In our approach to "doing the work of" the grant we are committed to:

- Seeking input and feedback in a low key but broadly inclusive manner
- Not advocating for any single approach
- Informing discussions through solid data and analysis
- Maintaining faith that there are good ideas yet to come
- Keeping expectations of the grant realistic—one step forward is one step better than nothing
- Doing work that is relevant for today's and tomorrow's circumstances
- Building on, being complementary to, and supporting efforts of others to address related issues
- Focusing our expertise and resources where they can be of greatest value
- Being informed and inspired by the experience and lessons of previous and concurrent efforts
- Moving beyond "admiring" the problem

In researching options to address access, we are interested in ideas that:

- Include local/community control and accountability
- Seek to expand private/public partnerships
- Reduce existing system complexities
- Are incremental and focused, preferably within a context of longer-range solutions
- Maintain consumer protections and choice but allow for regulatory or statutory simplification
- Are voluntary and incentive-based
- Target specific barriers and gaps faced by specific groups
- Refocus, redirect, and maximize existing delivery and financial resources
- Retain valued aspects of the current delivery and financing systems
- Challenge historical and existing assumptions about programs and systems
- Assist in maintaining Washington's gains of the past

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